

# Family Support Specialist Primary Certification Application

2014

## **Family Support Specialist Primary Certification Application** Developmental Disabilities Program (DDP) Department of Public Health and Human Services (DPHHS) State of Montana

### **Instructions:**

Read and follow the instructions when applying for Primary Certification as a Family Support Specialist (FSS). Three parts are required for submission and presented below in a checklist format. DDP Child and Family Services staff reviews submitted packets for certification.

### **Part I – Education and Training**

- ☐ Complete Sections A-C.
- ☐ Request official transcripts showing your baccalaureate degree in a human service field and are sent from colleges or universities attended directly to DDP:

**Family Support Specialist Certification**  
**Developmental Disabilities Program, DPHHS**  
**P O Box 4210**  
**Helena, MT 59604-4210**

- ☐ Include a copy of any license or certificate which will help support your application.

### **Part II – Employment History**

- ☐ Make additional copies of this section so each relevant employment experience in the human service field can be documented by your employer.
- ☐ Complete all sections for each employment experience including the signed **Employer Verification Signature Page**.

### **Part III – Letters of Recommendation**

- ☐ Request two letters of recommendation from individuals with knowledge of your work experience and skills in this field and submit them to:

**Family Support Specialist Certification**  
**Developmental Disabilities Program, DPHHS**  
**P O Box 4210**  
**Helena, MT 59604-4210**

**Send all application materials to:**

**Family Support Specialist Certification**  
**Developmental Disabilities Program, DPHHS**  
**P O Box 4210**  
**Helena, MT 59604-4210**

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## Part I – Education and Training

### A. Personal Information

<b>Applicant's Name</b> Click here to enter text.		<b>Date</b> Click here to enter text.	
<b>Home Address</b>		<b>Work Address</b>	
<b>Street Address</b> Click here to enter text.		<b>Street Address</b> Click here to enter text.	
<b>City</b> Click here to enter text.		<b>City</b> Click here to enter text.	
<b>State</b> Click here to enter text.	<b>Zip</b> Click here to enter text.	<b>State</b> Click here to enter text.	<b>Zip</b> Click here to enter text.
<b>Phone</b> Click here to enter text.		<b>Phone</b> Click here to enter text.	

### B. Education and Training

List all education and training relevant to this application.

<b>Name of School or Training Site</b>	<b>Degree/Training Received</b>	<b>Year</b>
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

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## C. Certification or Licensure

Check the appropriate box if you possess **current** certification, licensure, or work experience relevant to Primary Family Support Specialist Certification.

Qualification	Montana	Other State/Country?
Licensed Psychologist		
Registered Nurse		
Member of Academy of Certified Social Workers		
Special Education Certification or Endorsement		
Early Intervention Specialist Certification		
Licensed Speech/Language Pathologist		
Licensed Audiologist		
Licensed Physical Therapist		
Licensed Occupational Therapist		
Nutritionist		

Have you possessed relevant certification in the past? If yes, what:

Click here to enter text.

Do you have other qualifications relevant to this certification?

Click here to enter text.

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Name of Applicant

Click here to enter text.

## **Part II – Employment History**

Provide the information requested below to reflect current or most recent work experience. If you have more than one relevant work experience for DDP to consider, make copies of this form so each work experience is documented. After completion, send the form to the person who supervised your work (or another representative of the employer) for signature. Return the signed **Employer Verification Signature Page** with your complete application.

Employer Click here to enter text.		
Phone Click here to enter text.		
Supervisor Click here to enter text.		
Dates of Employment Click here to enter text.		
Position Title Click here to enter text.		
Full-time Click here to enter text.	Part-time Click here to enter text.	
Did/does the work performed for this employer take place in an early intervention setting?		
Yes Click here to enter text.	No Click here to enter text.	Unsure Click here to enter text.
How often does/did the position require you to provide direct services to children with disabilities and their families?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to gather assessment information about children's skills and behaviors?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to gather assessment information about families' concerns, wants, priorities, and resources?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to develop Individualized Family Service Plans with families?		

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Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to plan intervention strategies or other educational activities within the daily routine with children and families?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to implement intervention programs and services with children with disabilities?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to implement educational activities and services with families?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to coordinate community services and other resources?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to provide direct services <i>by yourself</i> to children with disabilities and their families?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
How often did/does the position require you to provide direct services <i>as a part of a team</i> to children with disabilities and their families?		
Never Click here to enter text.	Occasionally Click here to enter text.	Routinely Click here to enter text.
List other major job duties and the percent of your time engaged with those duties:  Click here to enter text.		

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Describe briefly, in narrative form, the nature of the work you performed/are performing for this employer or attach a position description for your current position.

[Click here to enter text.](#)

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Name of Applicant

[Click here to enter text.](#)

## Employer Verification Signature Page

**To the Employer:** The person named above is an applicant for Primary Certification by the State of Montana as a Family Support Specialist. Rules and Regulations dictate family education and support services for children with disabilities and their families are provided by qualified personnel who meet the highest requirements of the State for a Family Support Specialist. Your signature below indicates you have read the information provided by the applicant and that you verify the employment information provided by the applicant is true to the best of your knowledge.

Signature of Employer \_\_\_\_\_

Print Name \_\_\_\_\_

Title \_\_\_\_\_

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Name of Applicant

Click here to enter text.

## **PART III – LETTERS OF RECOMMENDATION**

**To the Writer:** The person named above is an applicant for Primary Certification by the State of Montana as a Family Support Specialist. Rules and Regulations dictate family education and support services for children with disabilities and their families are provided by qualified personnel who meet the highest requirements of the State for a Family Support Specialist. Your letter of recommendation should address your direct knowledge of the applicant's knowledge, skills, and work experiences relevant to providing family education and support services to children with disabilities and their families. Letters should be sent directly from the writer to the address below.

**Family Support Specialist Certification  
Developmental Disabilities Program, DPHHS  
P O Box 4210  
Helena, MT 59604-4210**